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	RTMENT OF HEALTH	AND HUMAN SERVICES	[n nr	Alashara)	PRINTER	D: 03/15/2 007
- VENIE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	M APPROVED 0. 0938-0391
STATEMEN STATELAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE	
,		DENTIFICATION NUMBER:	A. BUILI	•	COMPL	JETED
		09G010	B. WING	S		
NAME OF	PROVIDER OR SUPPLIER		- 		02/:	28/20 07
CAREC			}	STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE WASHINGTON, DC 20001	,	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	(10)			
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	1111000	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	s	W oc	00		
C.E.	random sample of t a client population of	vey was conducted from hrough February 28, 2007. A hree clients was selected from if five males with varying				
L GE	degrees of disabilities	es.				1
STATE	based on observation three day program, and management, a	ated utilizing the fundamental e finding of this survey were ans at the group home and interview with direct care staff and a review of the habilitation ecords to include the unusual ite.				
W 104	In this facility were tr	oted that the clients residing ansferred from 1447 Oak day, February 9, 2007. RNING BODY	W 10	The Governing Body will review a	ınd update t	ne .
, , , , ,	The governing body budget, and operating	must exercise general policy, g direction over the facility.		policies and procedures for commo outside services. As soon as the poupdated, the QMRP will train all sensure the policy is implemented.	licies are	4/26/200
en Lois Canada Ca Canada Canada Canada Ca Ca Ca Ca Ca Ca Ca Ca Ca Ca Ca Ca Ca	review, the facility's (not met as evidenced by; n, staff interview and record Soverning Body failed to ating direction over outside		SIGN & DATE		
	The governing body is and procedures for coprogram on Client iss	ailed to have written policies ommunication with the day uses as evidenced below: day program staff and day that Client #1, #2 and #3's		The QMRP will train traff to prope		
ODATOR:	T. C. C. LEW TEVERIE			implement the policy for communi	cation with	•
JUNY ORY	UIKECTOR'S OR PROVIDE	VSUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	THE WILL	

by deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that was safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days with the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 deficiencies are cited, an approved plan of correction is requisite to continued

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Event ID: 970J11

Facility 10: 096010

If continuation sheet Page 1 of 37

		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
	T of deficiencies Of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION NG	(X3) DATE SL COMPLE	JRVEY	
	·	09G010	B. WII	NG_		02/2	8/2007	
NAME OF F	PROVIDER OR SUPPLIER			57	REET ADDRESS, CITY, SYATE, ZIP CODE			1
CARECO	0 01				6417 KANSAS AVE, NE WASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIETE OFFICIENCY)	IULD BE	(X5) COMPLETION DATE	
051 053 55A75 2802	day program had no physician orders. F physicians order re at the day program the time of the survato ensure that this f of communication value to ensure that curre	ge 1 of been provided current Further review of each client's vealed that the orders on file expired in January 2007. At ey, the governing body failed actify had an effective system with each client's day program ent medical information was on gram in case of an emergency	W	104	The day program, including provis medical information and documen		14 /26/200	27
W.124	administered a noo Monday through Fri 2. The facility's gov system of accounta #4's day program si cash bi-weekly. (Se 483.420(a)(2) PRO RIGHTS The facility must en Therefore the facility parent (if the client of the client's medicand behavioral state	further noted that Client #3 is a dosage of medication from iday at his day program. Terning body failed to have a bility in place to protect Client tipend payment given to him in see W140) TECTION OF CLIENTS sure the rights of all clients, y must inform each client, is a minor), or legal guardian, cal condition, developmental tus, attendant risks of e right to refuse treatment.	W	124	The QMRP will ensure that the client the psychologist to determine his capa his stipend. The QMRP will coordina program to ensure that the client recei in a way that is consistent with the fac on protection and management of clie Each client and his/her guardian or legmaker will receive written explanation therapies recommended to address the physical and behavioral/mental health will include benefits and risks associa proposed treatment. Copies of the wrinotifications will be kept in the client client will be provided with a copy of human rights and intake/discharge policy.	city to manage the with the day ves his stipen illity's policy not funds. gal decision to of the eclient's. Explanation ted wit the tten second. Each the facility's	+/26/200	
	Based on observation review, the facility far parent, or legally au medical conditions, status, attendant ris	s not met as evidenced by: ons, interviews and record alled to ensure of each client, thorized party of the client's developmental and behavioral ks of treatment, and of the ment for three of the four e facility.						
RM CMS-25	67(02-99) Previous Versions	Obsciele Event ID: 970J11		F	acility ID: 09G010 If cont	inuation sheet	Page 2 of 37	1

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	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE S COMPL	
		. 09G010	B. WING	· · · · · · · · · · · · · · · · · · ·	02/2	28/2007
NAME OF P	ROVIDER OR SUPPLIER		s.	TREET ADDRESS, CITY, STATE, ZIP	····	<u></u>
CARECO	01	•		6417 KANSAS AVE, NE WASHINGTON, DG 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETION DATE
W 124	Continued From pa	ge 2	W 12	4		
, .	(Client #1, #2 and #	3)				
	The findings include	> :				·
	were informed of the psychotropic medic	ensure clients' #1, #2 and #3 e risks and benefits of their ations and behavior as evidenced below:				
Stall AND I	management plans	92 GAIDELINED DRIGM		See response above.		4/24/200
ganda a	administration on 2 that Client #1 had r Clonazepam 1 mg behavior. Review of administration reco	the evening medication /26/07 at 5:47 PM revealed eceived Tegretol 200 mg, and Risperdal 1 mg for of the medication rds and the Physician's orders: #1 receives an AM dosage of		See response above.	·	
	the same medication					
	(LPN), Qualified Mi (QMRP) and the re orders revealed the used in conjunction	icensed Practical Nurse ental Retardation Professional view of the client's Physician's aforementioned medication is with the Behavior (BMP) to address maladaptive				
	2/27/07 revealed the involved in his life a	conducted with the QMRP on at Client #1's mother is and will consents for necessary Further review of the record				
nagaries i e i	and interview with that written consented that make the medications had be	the QMRP failed to evidence t for the use of these sen obtained. At the time of as no evidence that Client's				
	rights to refuse me the risk and benefit	dications and to be informed of is of behavioral treatment, behavior support plan and the				
	i	•	ŀ	ļ	,	1

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		AND HUMAN SERVICES					: 03/15/2007 APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ייייייייייייייייייייייייייייייייייייי	PLE CONSTRUCTION	OMB NC (X3) DATE & COMPL	. 0938-0391 SURVEY ETED
	·	09G010	8. W	NG_		02/2	28/2007
NAME OF P	ROVIDER OR SUPPLIER		_ •	64	EET ADDRESS, CITY, STATE, ZIP CO 117 KANSAS AVE, NE IASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI TAC	ix	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETION COMPLETION
W 124	dated 10/15/06 revi able to give informa independent decision	sychological assessment ealed that Client #1 was not ed consent and/or make ons on his behalf regarding his g, placements, treatment,	W	124	-		
OAR SEE	administration on 2 that Client #2 received the Nattrexone 50 mg in of Nattrexone 50 mg in the Nattrexone and Rispland in the Nattrexone and Rispland further review of the Nattrexone with the Land further review of the Nature National Natio	icensed Practical Nurse (LPN) of the client's Physician orders nentioned medications were with the Behavior (BMP) to address Client #2's			See response above.		4/26/200
	Retardation Profes revealed that Client in his life and provide procedures. Further interview with the Gwritten consent for had been obtained there was no evide refuse medications and benefits of behind the consent for had been obtained.	d with the Qualified Mental sional (QMRP) on 2/27/07 the 2's sister is actively involved designatures for medical er review of the record and MRP failed to evidence that the use of these medications. At the time of the survey, note that Client's rights to and to be informed of the risk avioral treatment, which for support plan and the used dications.			-		
GRM CMS-28	67(02-99) Previous Versions	Obsolele Event (D: 970J11	1	Fa	 	If continuation she	et Page 4 of 37

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DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES					FORM	; 03/15/2 APPRO\	
- CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					OMB NO		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)). A. Bu		IPLE CONSTRUCTION	_	(X3) DATE S COMPLI		
		09G010	B. WI	NG		·	02/2	8/2007	
NAME OF F	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP	CODE			
CARECO	0 01				6417 Kansas ave, ne Nashington, DC 20001			-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAI	1X	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ON SHO	OULD BE	COMFLET	FION
W 124	Continued From pa	ide 4	W	124					\neg
	·	sychological assessment	1					l	
11	dated 4/10/06 revea	aled that Client #2 cannot			1				ĺ
este de la companya d		decisions on his behalf	i		••				i
	regarding his nabili treatment, financial	tation planning, placements, and medical matters.	ĺ						•
(1) [*]	, i				Į.				1
1	3. Observations of	the evening medication					i	4/261	200
S. S	that Client #3 receiv	/25/07 at 5:47 PM revealed ved Valproic Acid 15 ml and			See response above.		:	4/501	
∮ - Not E	Dilantin 100 mg for	behavior. Record verification			: '- '-		1		
; !	of the Medication A	dministration Record revealed						Ì	1
<u> </u>	that Client #3 also r	received Paxil 25 mg in the			1				
1	morning for anxiety	/depression.							
- VM	Interview with the L	icensed Practical Nurse (LPN)				•			
i	and further review of	of the client's Physicians order							
1 12	revealed the aforen	nentioned medications were							Ì
	used in conjunction Management Plan	· with the Benavior (BMP) to address maladaptive							1
<u> </u>	behaviors.	(DIVI) to address maladaptive							- 1
]			}						1
i ', F i:		d with the Qualified Mental							.
		sional (QMRP) on 2/270/07 t#3's sister was actively							
14. 11.	involved in his life a	and provided signed consents			•			1	1
	for necessary medi	cal procedures. Further	Ì		·				1
1	review of the record	and interview with the QMRP							
	railed to evidence ti	hat written consent for the use is had been obtained. At the							
:	time of the survey.	there was no evidence that					•		.
; ; ; ;	Client's rights to ref	use medications and to be							1
		and benefits of behavioral							
		cludes the behavior support of psychotropic medications.	-					1.	
,									
	The review of the p	sychological assessment							-
	uated 1/3/0/ reveal	ed that Client #3 cannot make ons on his behalf regarding his						'	
	habilitation planning	g, placements, treatment,							1
									1
ORM.CM5-25	67(02-88) Previous Varsions	Obsolere Event 10:970J11		Fa	acility ID: 06/5010	If con	tinuation she	et Page 5	` ⊓€ 37

If continuation sheet Page 5 of 37

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		AND HUMAN SERVICES & MEDICAID SERVICES	•			FORM A	\PPROVED 0 938 -0391	
SYATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY	
	;	09G010	B. W/1	رو		02/28	/2007	
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			7
CARECO	01			I	M7 KANSAS AVE, NE MASHINGTON, DC 20001	,		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		FROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(XS) COMPLETION DATE	
W 124	Continued From pa	ge 5	W	124				7
W. 125	financial and medic 483.420(a)(3) PRO RIGHTS	al matters. TECTION OF CLIENTS	w	125	The facility will hold a Residents' meeting to discuss door alarms. T	he Human		
1 (42) - 1 (2) - 1 (2)	Therefore, the facil individual clients to of the facility, and a	nsure the rights of all clients. ity must allow and encourage exercise their rights as clients as citizens of the United States, to file complaints, and the right			Rights Committee will review the alarms to determine if it is the lea measure for the client's safety, and does not unnecessarily restrict the other clients living in the home.	st restrictive d ensure it is		37
To,	Based on observation review, the facility to	is not met as evidenced by: ion, interview and record failed to address the client's y to ensure their rights were	•					
VV V/ J	#3's psychological clients were unable decisions. There we had ensured a sur- guardian to ensure	ce: ce W124] Clients #1,#2 and assessment reflect that the e to make independent as no evidence that the facility rogate decision- maker or e each client's rights to be s to refuse treatment was being			The QMRP will submit guardianship packages to DDS for the identified c QMRP will track the status of the resubmitted.	lients, The	4/26/200	27
	revealed that the factor all exits through observation reveal opened it activated	February 26 - 28, 2007, acility has door alarms placed nout the facility. Further ed that when the door is the alarms, which had a loud a lert the direct care staff.			The Resident Council will meet to d alarms and choose a different tone if approve of the tone currently in use. W125 above.	they do not	!	00,
	were place on the	QMRP revealed the alarms door due to Client#5 or and Client#2 history of		,				

Evant ID: 970J11

Facility ID: 09G010

If continuation sheet Page 6 of 37

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		AND HUMAN SERVICES				PRINTED: FORM / OMB NO.	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		TIPLE CONSTRUCTION NG	(X3) DATE SU COMPLET	RVEY
		09 G010	B. Wil	NG_	<u> </u>	02/28	/2007
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, SYATE, ZIP CODE		
CARECO	01			1	6417 KANSAS AVE, NE WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X3) COMPLETION DATE
W 125	Continued From pa	ige 6	W	12:	5		
par 6	elopement behavio QMRP did not evid in the facility had be the type of alarm to	r. Further interview with the ence that all the client residing een involved in the selection of the and/or participated in reast restrictive options prior					
OSY MATERIAL	the other client's ar been informed of ti installation. Furthe provide evidence ti Committee had rev installation of the d	rds failed to evidence that all addor their representative had neir rights prior to the alarms or review of the records failed to nat the Human Rights view and discussed the oor alarms, other least as and the rights of all the other actility.		,			
	28, 2007 at approx review Human Right 10/26/06 revealed recommended for interview with the reclonoscopy had need for a consent for the colonoscopy	baseline colonoscopy. Further hurse revealed that the ot been completed due to the for this procedure. The need y was delayed due to the therefore the facility failed to			The QMRP will follow up with DDS assignment of a legal guardian for Cliconsent for medical procedures.	on the lent #4 to give	4/26/2007
W 140	was no evidence the system to ensure it colonoscopy. 483.420(b)(1)(i) Cl. The facility must exthat assures a full it.	eurvey, four months later, there not the facility have a effective informed consent for Client #4's LIENT FINANCES stablish and maintain a system and complete accounting of ands entrusted to the facility on	w	14	The QMRP will ensure that copies of statements are available in each clien facility. See response to W104 #2.		4/26/2007
©⊼M CMS-25	687(02-99) Previous Version	s Obsoleta Event ID: 970J11			Facility ID: 09G010 If con	ntinuation shee	t Page 7 of 37

if continuation sheet Page 7 of 37

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 03/15/2007 APPROVED <u>:</u> 09 <u>3</u> 8-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE S	URVEY
***		09G010	B. WING		02/2	28/2007
NAME OF RECO	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE. WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 140	Continued From pa	age 7 .	W 14	0		
CUE : CUE : CUEA STATE ABU FE	Based on staff inte the facility failed to ensures a complet clients' funds that a	is not met as evidenced by: rview and review of records, rnaintain a system that e and accurate accounting of are entrusted to the facility for nts residing in the facility. #3)			1. 1.	
1878pr	month for persona	le: d #3 recieve SSI of \$70.00 per I expenditures and according to hts are not able to manage their				
in the second	February 28, 2007 review of Client #2 not evidence any the 4th quarters. Althoresident ledger showithout the current	acility's Director (FD) on at approximately 3:00 PM and and #3's financial records did bank statements for the 3rd and bugh a copy of the agencies set was provided for review, a bank statement verification of deposits as listed on the ledger ed.		See response above.		4/26/200
	28, 2007 at approx CLient #1's finacia main office. The I record would be fo from the main office	FIED MENTAL	W 18	See response above.	·	4/26/200
	Each client's activ	e treatment program must be				

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		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: FORM A OMB NO. (PPROYED	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY	
		09G010	B. Wil	NG		02/28	/2007	
WAWE OF P	ROVIDER OR SUPPLIER		••		EET ADDRESS, CITY, STATE, ZIP CODE	. ,		
CARECO	01	·		L	17 Kansas ave. Ne Ashington, DC 20001			
(X4) 10 PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	1ήD θΕ ∫	(X5) COMPLETION DATE	
W 159	Continued From pa	ige 8	W	159		!		
, <u></u>		ated and monitored by a ardation professional.						
AND P	Based on observate review, the facility (Professional (QMR)	is not met as evidenced by: lon, staff interview and record Qualified Mental Retardation P), failed to adequately and coordinate each client's e:						
CAR	and/or reassessms	ed to ensure that assessments ents of each clients' I behavioral strengths and]			The QMRP will ensure that assessment client's needs are completed.	f for each	4/z6/z60 4/z6/z60	7
	employee had bee training that enable	ed to ensure that each in provided with adequate as the employees to perform fectively, efficiently and W189]			The QMRP will ensure that each emplorovided with adequate training to perform duties effectively and competently.	oyee is form his/her	4/26/200	7
	staff recieve prope on implemtation ar	ed to ensure that the direct care referred training from the nursing staff and maintenance of support on mary care for Client #1. [See			The QMRP will coordinate with nursin provide employees with the proper training care prescribed by the p physician for Client #1.	ning on	4/26/260	7
	measures had bee	ed to ensure that restrictive in approved by the Human (HRC). [See W262]			The QMRP will ensure that restrictive approved by the HRC.	measures are	4/26/20	U
	behavior interventi of behavior modific	ed to ensure each client's on program, including the use eation drugs, was conducted n informed consent. [See			The QMRP will ensure that clients' be intervention programs, including the conducted only with written informed response to W124.	ise of drugs, is	4/26/20	37

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CENTERS FOR MEDICARE & MEDICAID SERVICES CHATEMENT OF DEFICIENCIES CATOR PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(Y1) PROVIDER/SUPPLIER/CUA	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SU COMPLE	
		09G010	B. WING		02/28/2007	
AME OF PE	ROVIDER OR SUPPLIER			ET ADDRESS. CITY, STATE, ZIP COL TO KANSAS AVE, NE	DE	
)ARECO	01		1 "	ASHINGTON, DC 20001		
(XXI) ID PREFIX TAG	/EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
W 159	Continued From (W 159	See response to W104 #1.		4/24/20
	implement Huma recommendations	ed to ensure facility failed to n Rights Committee (HRC) s failed to review, monitor and s to the facility about its				
ing. Legis. Calor	practices and pro protection of clier	grams as they relate to it rights. [See W264]		C		4/24/20
	program was pro information for C	iled to ensure that each day vided with current medical lient #1, #2 and #3's day of an emergency. (See W104).		See response above.		
CAR.	8. Interview with on February 8, 2	the day program case manager 007 at approximately 10:45 AM y program habilitation records		See response above. The QMRP of the completed ISP to the Day I time it is submitted to DDS for a approved ISP cannot be transmitted.	Program at the same proval. The	4/26/2
7 SP (#1's Individual Si According to the meeting was hel	e that a current copy of Client upport Plan (ISP) was on file. day program staff the ISP d on October 16, 2006.		received from DDS.		
	Interview with the	e program director revealed that g meeting occurred a couple of vever, they had not received a				
13 \$.	Interview with the document was to Department of D	e QMRP revealed that the ISP eing processed by The Disability Services and the current				
S. 4872 - W. 189	comprehensive available for dist	function assesssment was not yet	W 189	See response to W159 #2.		4/261
- 1	The facility mus	t provide each employee with uing training that enables the		des tesponie -2 ·· ver ··		
(1)//5 	employee to pe efficiently, and o	rform his or her duties effectively,				
. •	This STANDAR	D is not met as evidenced by:				

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES		_		FORM	03/15/2007 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XC2) M A. BUI		LE CONSTRUCTION	(X3) DATE S COMPLE		
		09G010	B. WII	NG		02/28/2007		
NAME OF PI	ROVIDER OR SUPPLIER			64	EET ADDRÉSS, CITY, STATE, ZIP CODE 117 KANSAS AVE, NE 1/ASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ix	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	ついばひ 多毛	COMPLETION DATE	
W 189	review, the facility employee had bee training that enable his or her duties ecompetently. The findings included the facility of approximately 12: sitting at the table Further observations of the first standing on his hand. The 1:1 standing on his hand the Client however, the Cliebib from around	tion, interview and record failed to ensure that each en provided with adequate es the employees to perform ffectively, efficiently and de: on January 27, 2007 at 38 PM revealed that Client #3 with his lunch in front of him. ons revealed Client #3 1:1 Staff at tempted to place a bib in her aff attempted to place a bib is neck on several occasion, and at each attempted pulled the is neck and threw it on the floor. attempted to place an built up client #3's right hand, but he e spoon. The 1:1 staff oted to place the spoon in the ver, all attempts were e 1:1 then commented "He		189	The QMRP will schedule training for diets with the Registered Dietician; provide training to all staff on each oprotocols.	hè QMRP wi		
	Observation during same day with the dinner table differ staff was implement of the with the adaptive never place a bib. Additionally, the sover hand assists apoon without amposerved to mix.	ng the evening meal on the e client was observed at the tent 1:1 staff (Staff #2). The 1:1 enting different feeding 1:1 staff set up the table area equipment. The evening 1:1 around the Client #3's neck. evening 1:1 staff provided hand ance using the built up handle y difficulty. The 1:1 was also small amount of applesauce with food. Client #3 completed a						
90RM CM9-	 2567(02-99) Previous Version	ons Obsolete Event ID: 97031	1	F	acility ID; 08G010 If co	ntinuation she	et Page 11 of 37	

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES				FORM): 03/15/2007 1 APPROVED): 0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TPLE CONSTRUCTION	S B TAO (EX)	SURVEY
		09G010	B. Wi	NG_			
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/2	28/2007
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W 189	Continued From pa	ge 11	w ·	189			
W 214	Professional (QMRI care staff at Client # regular 1:1 assigned the 1:1 observed at been trained to the procedures with Client # procedures with Client # called in to work stored in the work stored in the client # compatible of the direct care stamping and the direct care stamping and the client # client * cl	Cervical Collar prescribed for 22, W331 and W159] DIVIDUAL PROGRAM PLAN functional assessment must pecific developmental and nent needs.	W 2	214	The QMRP will have the PT complete: If the collar is recommended and approper PCP, the QMRP will train staff on its put the QMRP will coordinate with the Int Team to ensure that updated compreher functional assessments are completed for and that programming reflects steps to a client's specific developmental and behimanagement needs.	ved by the roper use. erdisciplinarisive or all clients, address each	4/2c/2007
	dased on observation review, the facility factorists for the sample. (Client's the sample.)	·					
1	The findings include:	,				• !	
And the second of the second o	administration on 2/2 that Client #1 had red	ne evening medication 26/07 at 5:47 PM revealed ceived Tegretol 200 mg, nd Risperdal 1 mg for the medication			The QMRP will ensure that a psychiatri is completed and placed in each client's	c assessmen record.	4/24/2007
RM CMS-2587	7(02-99) Previous Versions C	baciete Event ID: 970J11		Fac	liby ID: 09G010 If continu	stion sheet f	Page 12 of 37

DBM CMS-2587(02-99) Previous Versions Obsolete

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DEDAG	STMENT OF HEALS	T A				. !	
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. AG	LEGOLATORY OR L	SC IDENTIFYING INFORMATION)	TAG	j	CROSS-REFERENCED TO THE APPR	OPRIATE	COMPLETION DATE
W 214	Castinua d E				DEFICIENCY		<u> </u>
W 214	1		W 2	214	1	-	
	revealed that Client	ds and the Physician's orders					
ماريا ماريا	the same medicatio	#1 receives an AM dosage of					
н '					1		ĺ
٠.	Interview with the Li	censed Practical Nurse			į		Ì
1-n	l (LPN), Qualified Me	ntal Retardation Professional			1		1
	(CIMICH) and the rev	/lew of the client's Physician's L					}
	used in conjunction	aforementioned medication is			:		
	Management Plan (BMP) to address maladaptive					
	behaviors.	, and an analysis of the state					
	Person of the Letter						
	Meview of the nabilit	ation records revealed a sychosis. Onychomycosis-Nai			:		+
	Adapt Behavior and	Profound Mental retardation,				•	
	Further review of the	records failed to evidence a					1
Ė,	psychiatric assessm	ent					ĺ
	2 Observations of #	<u> </u>			.		1
ΨŲ.	administration on 2/2	he evening medication 26/07 at 5:47 PM revealed			See response above.		4/26/2001
· '	that Client #2 receive	ed Risperdal 3 mg and					11/2012
120	Buspirone 15 mg to i	Mahage behavior Record		- 1	<u> </u>		
; i	vernication of the Me	dication Administration		i			
	Natroyons 50 mail	Client #2 also received					
.	of Naitrexone 50 mg	the AM and another dosage twice daily. Additionally,					
	Chent #4 also receive	es an AM dosage of the		1			
ĺ	Buspirone and Rispe	rdal.			Į.		1
`	Intervious with the same						i (
	and further review of	ensed Practical Nurse (LPN) the client's Physician orders			!		1
	revealed the aforeme	entioned medications was			! !		! !
·	used in conjunction w	/ith the Rehavior			:	•]]
	Management Plan (B	MP) to address Client #2's					j
. 1	maladaptive behavior	s.					
	Review of the habilita	tion records revealed that			1		
	Ullent #2 has a diaoni	osis of Atvoical			,		
	Psychosis/Maladaptiv	e Behaviors, Autism and		}	•	•	

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DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTEL	0: 03/15/2007 APPROVED
STATEME	NT OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				OMBINO	0. 0938- 0391
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	<u></u> .	09G010	a. wi	NG			
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W 214			W	214		;	+
; ₁	Profound Mental Retailed to assessment	etardation. Further review of evidence a psychlatric					
	3 Observations of	M	i	}	See response above.	1	4/26/2007
, -	administration on 2/ that Client #3 receiv	the evening medication 26/07 at 5:47 PM revealed ed Valproic Acid 15 ml and				· ·	
† ; * ,	of the Medication Ac	behavior. Record verification Iministration Record revealed eceives Paxil 25 mg in the					
 f-:	revealed the aforem used in conjunction	censed Practical Nurse (LPN) f the client's Physicians order entioned medications were with the Behavior BMP) to address maladaptive					
	diagnosis of Adjustm Unspecified-Chronic	and Profound Mental					
	approximately 3:00 F	07 with the QMRP at PM and record review to last Physical Therapy npleted on 5/1/05.		P	The QMRP will have the PT assess or persons with visual impairments 'T will revise ambulation protocols QMRP will train all staff on the reviotocols.	in the home. The	ie
	Client #2 had a Physi dated 4/26/06. Furti not evidenced that th updated these safety ambulating up and do facility. According to assessment had not	ation records revealed that ical Therapy/Fall Protocol her review of the protocol did a PT had amended and/or procedures to reflect safe own the stairs in the new the QMRP no mobility been completed for the nally, no recommendation					
	7(02-99) Previous Versions Of						
12 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	· / ANDUS ARIZIOUS OF	osolete Event ID: 970J11		Facility	ID: 09G010 If con	tinuation sheet P	1000 11 -107

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		096010	B. WING	ā		7	
NAME O	F PROVIDER OR SUPPLIER		- 			<u> </u>	<u>/28/2</u> 007
CARE	CO 01		[]	TREET ADDRESS, CITY,	STATE, ZIP CODE		
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(X4) JD		TEMENT OF DEFICIENCIES	ү——	WASHINGTON, DC		1	
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- 1.0	ייים ואט ואט ואט ואט ואט ווייים	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERE	CTIVE ACTION SHO	ULD BE	COMPLETION DATE
W 21	1 0 1				OEFICIENCY)	I KIATE	EA!=
# Z [Tarrended Light ba	ge 14	W 21	4			+
	nan been made and	no new assessment of the	,	•			
1. July	THE STOCK HOLLINGS COVICE	DIMENT had been us district.			į		la de la companya de
• •	ensure that Client #	Protocol/Fall Prevention to 2 safe mobility in the new			,		! i
#	group home.	a sale mobility in the new			ļ		{
DE C		-					
ri Di	5. Observation on F	ebruary 26 and 27, 2007		1	į		1.1
ATV Justi	I revealed the 111 dite	Ct care staff accidance to		See response above.	. !		4/26/2007
	TOREILLA I, STOOD DEN	INCIDE client at the ten as 4			, ;		' '
	L PAGALLIEUT PIGIT MEN S	IDD DOSITIONAD the allege.			, ,		!
	encourage the client	he 1:1 one staff then to proceed down the steps			·		
	Serie confidente to sig	DO DOMINA THA AGASE L -			1		
	proceeds down the t	pasement stainvell			J.		}
	1	·			}		1
	Interview on 2/28/07	with the QMRP at					1.
	approximately 3:00 F	'M and review of the evealed that Client#1 is blind	•		į		i 1
<u> </u>	I area researed and Dictor	DI/FRII Proventice is sis			1		1
43	for safe mobility with	n the group home			!		1
	1				÷		1
-	Review of the Fall Pr	otocol/Fall Prevention dated			İ		
	H/20/Va alp not reflec	thow the direct core exect					1
	i was to assist Client #	I (a safely ambulata as			j		i l
(,) ··	the OMRP the protoc	group home. According to oi had been developed for					
	nae or nie Dienicije ta	Clift/ Which did set L		!	,		!
} '		/ OT 7D A Protocol atul			ĺ		
	evidenced Nat ING N.	Dad amended and/act			!		
:	abadra nieże żajeta	DIOCOMUNICATION OF SOME			!		1
·]	Tarribulation up and do	Will the chaire in the ending		÷			
`` ·	protocol was available	the QMRP no new safety					
		1		!			
	Note: It should be not	ted that no blind mobility		,	i		
	gggggggrieur USO Deel	COMbioted and at the k		•			.
7	ALMIN SOLVEY THE WALL	IIPOSOCE CISH SECRE			į]
-	installing sarety rails for group home.	or the second level of the			į		
<u> </u>			.		1	. 1	
4 CMS-256	7(02-99) Previous Versions Ob	Solete Event (D: 970J11	<u>_</u> _				
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, <u> </u>	CCCS FOR MEDICARI	E & MEDICAID SERVICES					PRINT	ED: 03/15/200
		(X1) PROVIDER/SUPPLIER/CLIA		· <u>-</u>			OMB N	RM APPROVED 10. 0938-0391
i www.pro	N OF CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DAT	E SURVEY
		1	A. BUII	LDING		į	COM	PLETED
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	F PROVIDER OR SUPPLIER		<u> </u>	STOCK	ADDED		0:	2/28/2007
CARE	CO 01			6417	ADDRESS, CITY, STATE, ZIP CI KANSAS AVE, NE	ODE	,	
(X4) ID PREPIX	SUMMARY STA	TEMENT OF DEFICIENCIES			HINGTON, DC 20001	i		•
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)			(XE) COMPLETION DATE
	4 Continued From page	ge 15	W 2	14		\	 -	
ρο Σ DE	receives a bi-weekly	e FD on February 28, 2007 at PM revealed that Client #3 stipend from his day urther interview with the (FD)		ĺ	ercsponse to W104#2	! ! !	•	4/20/200
	amount of money given these funds were given the FD the day programming the following the following the fundamental fundaments and fundaments are the fundaments of the fundam	regency was not aware of the ven Client #3 and/or when ven to the client. According to am Indicated that it was his y directly.						
And the second s	establish a system el amount of the disburi agency's governing b effective system of ac	and financial records revealed hade several attempts to insure disbursement and the sement bi-weekly. The hody has not established a countability to ensure when shipping to Clost #4					:	
er er er	Client #4's ability to m funds. There was no e fully assessed to hand received from his day.	program. The facility's						
	the facility dinner at appropriate the facility dinner at ap Client #3 is prescribed	oruary 27, 2007 at the day oximately 12:40 PM and at proximately revealed that a Pureed, Regular diet.		evalu	QMRP will have the Registere ate client #3's nutritional neco esponse to W189#1	d Dieți Is and s	cian re- supports.	4/20/2007
		n he eats", however, the				:		
, , , , , , , , , , , , , , , , , , ,	7(02-89) Provious Versions Obse	olete Event ID; 870J11	Fac	pility ID: DB	G010 If con-	tiol (134)		

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""""一"	DTMENT OF CO.				·	: 1	생활 어로인가 () 웹 / .
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ANT ATTEME	ENT OF DEFICIENCIES	& MEDICAID SERVICES				! ! FO	RMAPPROVED
ARD PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) !	MUL	TIPLE CONSTRUCTION	OMBI	O. 0938-039
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NAME OF	PROVIDER OR SUPPLIER	200010		_		∯ ; o₂	<u>2/28/</u> 2007
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	—.			Ι,	6417 KANSAS AVE, NE		
(X4) ID	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 214 Continued From page 16 PM 1:1 had no difficulty assisting him with hand over hand feeding. Additionally, the 1:1 staff during the dinner mixed applesauce periodically with his meat and Client #3 consumed 100% of his food. Review of the physician order dated February 1, 2007, revealed the diet order as "Pureed - Do Not Feed In Bed". Review of the Nutritional Assessment revealed that the assessment had expired 12/7/07, Further review did not critical			ا	WASHINGTON, DC 20001	<u> </u>	•
TAG	. IEAUD DEFICIENCY	MUST RE POLCEDES	ID PREF	ıχ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO	ПОИ	(X5) COMPLETION
		SO ISENTI TING INFORMATION	TAG	•	CROSS-REFERENCED TO THE APPR	OPRIATE	COMPLETION
W 214	Continued From page	70.16		—	DEFICIENCY)		
	PM 1.1 bad on diffic	ye io	W 2	214		Ţ.	
47,17	over hand feeding	Additionally the 1-1			i	1	
	I annual we amber wi	XPC SDNIASSURE pododlosik.			,	!	ł
•	H with this meal and Ci	ient #3 consumed 100% of				}	
OE	his food.					:]*
100	Review of the physic	NOO ORDON HARALES				į	
STATE	~vv/, revealed the d	let order as "Purson i Dai Marki.					
A1460 (Treed in Bed., Revie	Winfitha Nutritional				1	
	Assessment reveale	d that the assertment but				1	
******	evbiled (5///0/, 1-0)	Ther review did not ovidence. I				Į	
4	nutritional needs and	ad reevaluated Client #3's			[.		. }
W 249	483.440(d)(1) PROG	RAM IMPLEMENTATION	186 00	40		•	-
. ,	1		W 2	49	The QMRP will ensure that all direct su	pport staf	f are
4	As soon as the interd	lisciplinary team has			trained to correctly implement client proson as the interdisciplinary team has for	adramen in	h I
,	each client must race	individual program plan, ive a continuous active		ļ	as a district disciplinary team has a	rmulated	it 4/26/2007
	treatment program co	ine a continuous active			į	i	1
	interventions and ser	vices in sufficient number			į	:	
	and reductor to sho	DOM the arbievement of the				!	i
, .	plan.	the individual program			,	•	
' · i	P.IZII.			1	•	:	1 1
1						;	i
€ 2m ·	#11 OT 13 P				į	1	
<u>9</u> E	Based on observation	not met as evidenced by:			•	i	
	review, the facility fails	to thist as evidenced by: a staff interview, and record ad to ensure that one out of			÷	I	j
	are ringe clients in the	Bamnie received southwest				j l	1
	active treatment progr	ams to address their needs.				1	1
-						i	1
·	The finding includes:		,		1	<u>:</u>	
V .	The facility's direct car	e staff failed to consistently		.		: !	1
	mandicing in Click #1 R	Phavior support steel as			The OMPD will	i ,	
[]	written as evidenced b	elow:			The QMRP will request the psychologist direct care staff on the proper implement	to train	j
	During observation of t	the modication			behavior support plan.	ation 10 th	4/26/2007
				ļ	-	I	71001001
* CMS-2561	7(02-69) Previous Versions Obs	cicle Event ID; 970J11		2011	ly ID: 09:301g		
			,	#4II	If continue	tion sheet	Page 17 of 37

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 03/15/2007 APPROVED : 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE S	URVEY
		095010	8. WII	4G_		1 102/2	8/2007
NAME OF F	ROVIDER OR SUPPLIER 0 01			6-	EET ADDRESS, CITY, STATE, ZIP CODE 417 KANSAS AVE, NE VASHINGTON, DC 20001	0212	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	(TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ÚLO SE	(X5) COMPLETION DATE
W 249	administration on F approximately 5:47 medication room ethe repeatedly spit it assigned to the clie paper towel to wipe nurse to speed up to process. The medication and the the client to the din At no time was statinto the bathroom to the the client to the din At no time was statinto the bathroom to the the the committed procession in which? 483.440(f)(3)(i) PROCHANGE The committee shomonitor individual propropriate behaving the opinion of the client protection and the client protection and the spinion of the client protection, the facing the spinion of the client protection, the facing the spinion of the client protection, the facing the spinion of the client protection and the spinion of the client protection, the facing the spinion of the client protection and the spinion of the spinion of the client protection and the spinion of the s	ebruary 26, 2007 at PM, Client #1, while in the chibited a spitting behavior. In his hands. The 1:1 Intrepeatedly gave him a dry In his hand, and encouraged the the medication administration se administered the client 1:1 staff proceeded to take ing room table for his dinner. If observed to take the client o wash his hand. MMRP on the same day, If Client #1's target behaviors witting and the behavior support dure to wash his hand on each the spits in his hands. OGRAM MONITORING & uld review, approve, and programs designed to manage vior and other programs that, e committee, involve risks to		249		idual	4/26/2007
	The findings include	·					
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 970/11		End	10 10: 09:3010	2	

OF TERM	H AND HUMAN SERVICES			PRINTED: 03/15/2007
. CENTERS FOR MEDICAR	RE & MEDICAID SERVICES	_		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	09G010	B. WING	·	03/38/2003
NAME OF PROVIDER OR SUPPLIES		S	TREET ADDRESS, CITY, STATE, ZIP CODE	i i 02/28/2007
CARECO 01			6417 KANSAS AVE, NE WASHINGTON, DC 20001	
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES	L_ ID		<u> </u>
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W 262 Continued From p	page 18	10/ 20		1 1
There was no and monitored Clipsychotropic medianagement Propheral Support	evidence that the HRC reviewed ent #1, #2 and #3's ication and Behavior gram that included the use of t interventions. (See W124) ROGRAM MONITORING &	W 26 W 26	The QMRP will track submissions to	DDS requesting
The committee sh are conducted only consent of the clie minor) or legal gua	ould insure that these programs y with the written informed nt, parents (if the client is a ardian.		legal guardians for clients who do no capacity to make decisions themselve to W124	thave the es. See response 4/26/2007
review, the facility client's behavior in the use of behavior conducted only with	is not met as evidenced by: ifion, staff interview and record failed to ensure that each tervention program, including r modification drugs, was in the written informed consent for three of the three clients in #1, #2 and #3)	·		
The findings includ	e;			
that Client #1 had r Clonazepam 1 mg behavior. Review of administration reco	rds and the Physician's orders		Client #1 will be assessed by the psydetermine his need for a legal guardiz to W124 and W125 #1	thologist to in. See response
(LPN), Qualified Me (QMRP) and the re- orders revealed the was used in conjunc	icensed Practical Nurse ental Retardation Professional view of the client's Physician's aforementioned medication ction with the Behavior			
M CMS-2567(02-89) Previous Versions	Obsolete Event ID: 970J11	Fa	cility ID: 09G010 If contin	vation sheet Page 19 of 37

. CENT	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				1	FORN	D: 03/15/2007 APPROVED
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	WUL7	TIPLE CONSTRUCTION	<u> </u>	<u> ФМВ ИС</u>	<u>). 0938-0391</u>
AND FOAT	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BU			۱۱۹	DATE S	SURVEY ETED
		09G010	B. WI	NG_				hn/n
NAME OF	PROVIDER OR SUPPLIER			ST	REST ADDRESS, CITY, STATE, ZIP CODE	╨	02/2	28/2007
CARE	CO 01			(6417 KANSAS AVE, NE WASHINGTON, DC 20001	i I		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	_		<u> </u>	<u> </u>	
PREFIX TAG	((EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG	ЭX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ria de la compa	A be	(X5) COMPLETION DATE
W 26	The second section of the page		W:	263		 -	<u> </u>	
Profit Circus	Management Plan (behaviors (i.e. physidestruction, noncon	BMP) to address maladaptive loal aggression, property apliance, SIB, clothes sturbation, smearing feces	***	200			 	
	capable of compreh psychotropic medica assistance to comproptions. Additionally	th the nurse conducted on the that Client #1 is cognitively ending the side effects of his ation regimen and required full when drisk and treatment or this clients is unable to decisions without assistance.						
Na Property of the Control of the Co	nas family involvements however, there was or a family member a signed informed contractive medical management progration assessed for the	ations and restrictive behavior ms. In addition, the had not se need of legal guardianship se decision making as it						
1	ensure that surrogate available to assist Cl consent as it relates habilitation needs pri psychotropic mediation	Of to prescribing each cliente						
	that Client #2 receive Buspirone 15 mg for verification of the Mei	ne evening medication 6/07 at 5:47 PM revealed d Risperdal 3 mg and behavior. Record dication Administration Client #2 also received			See response above.			4/26/2007
RM CMS 25	i87(02-99) Previous Versions Oi	esolete Event ID: 970J11		Feci	lity ID; 09G010 (6	+		
i* '					ir contin	Jeti	on sheet P	age 20 of 37
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		AND HUMAN SERVICES & MEDICAID SERVICES				i í	FORM A	03/15/2007 APPROVED 0938- <u>0</u> 391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION IG) DATE SUI COMPLET	RVEY
_		09G010	B. W(NG_			02/ 2 8	/2007
NAME OF P	PROVIDER OR SUPPLIER		· · · · · · ·	STR	REET ADDRESS, CITY, STATE, ZIP CODE			
CARECO	0 01 .				417 KANSAS AVE, NE VASHINGTON, DC 20001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD.	BE	(X5) COMPLETION DATE
W 263	of Naltrexone 50 mg	n the AM and another dosage g twice daily. Additionally, in AM dosage of the	W	2 6 3				
	and further review of revealed the aforem used in conjunction Management Plan (maladaptive behavi Self-injurious pehavi	icensed Practical Nurse (LPN) of the client's Physician orders nentioned medications were with the Behavior (BMP) to address Client #2's ors (i.e. physical aggression, viors, property destruction, or refusing meals and playing						·
ore For For V	same day indicated capable of comprei- psychotropic medic assistance to comp options. Additional	th the nurse conducted on the I that Client #2 is cognitively rending the side effects of his ation regimen and required full rehend risk and treatment y this client is unable to make ons without assistance.			,		3	
	has family involvem however, there was or a family member signed informed con psychoactive medic management progra had not been asses guardianship to ass	MRP revealed that Clients #2 tent in their habilitation; no evidence that an individual was involved in providing insents for the use of rations and restrictive behavior ams. In addition, the clients issed for the need of legalist them with the decision to their habilitation.					·	
15 mag 12 - 1	ensure that surroga available to assist C consent as it relates	ence that the facility had te decision maker were Client #2 with written informed to the treatment and rior to prescribing each clients						

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Facility ID: 09G010

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幽 025/04/ PRINTED: 03/15/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G010 02/28/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE. NE CARECO 01 WASHINGTON, DG 20001 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY) W 263 Continued From page 21 W 263 psychotropic mediation regimen and $P_{m}^{A}\partial m \in \mathbb{R}^{n}$ implementation of their behavior support plans. See response above. 3. Observations of the evening medication administration on 2/26/07 at 5:47 PM revealed that Client #3 received Valproic Acid 15 ml and Dilantin 100 mg for behavior. Record verification of the Medication Administration Record revealed that Client #3 also receives Paxil 25 mg in the morning for anxiety/depression. Interview with the Licensed Practical Nurse (LPN) and further review of the client's Physicians order revealed the aforementioned medications were used in conjunction with the Behavior Management Plan (BMP) to address maladaptive behaviors (i.e. Self-Injurious Behaviors and Bruxism), Further Interview with the nurse conducted on the same day indicated that Client #3 is cognitively capable of comprehending the side effects of his psychotropic medication regimen and required full assistance to comprehend risk and treatment options. Additionally this client is unable to make independent decisions without assistance. Interview with the QMRP revealed that Clients #3 has family involvement in their habilitation; however, there was no evidence that an individual or a family member was involved in providing signed informed consents for the use of psychoactive medications and restrictive behavior management programs. In addition, the clients had not been assessed for the need of legal guardianship to assist them with the decision making as it relates to their habilitation. There was no evidence that the facility had

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CENTE	RS FOR MEDICARE T OF DEFICIENCIES	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	260, 241, 11		FORM OMB NO	APPROVE . 0938-039
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDIN	IPLE CONSTRUCTION	(X3) DATE S	
	·	090010	B. WING_		1 102/2	8/2007
	ROVIDER OR SUPPLIER	,		REET ADDRESS, CITY, STATE, ZIP CODE 1417 KANSAS AVE, NE		OIZBO I
CAREC) 01 			VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (PACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATI	III to a E	COMPLETICA DATE
⁴ √v 263	Continued From pa	ge 22	W 263		<u> </u>	 -
	available to assist C consent as it relates habilitation needs p psychotropic media implementation of the	neir behavior support plans.				
W 264	483.440(f)(3)(iii) PR CHANGE The committee sho	OGRAM MONITORING & uld review, monitor and make acility about its practices and	W 264	The Human Rights Committee will be include clients and additional community Policies and procedures will be updated through review of facility practices and	ty inembers. to ensure programs	4/20/2
piece	programs as they re restraints, time-out or noxious stimuli, o behavior, protection	elate to drug usage, physical rooms, application of painful control of inappropriate of client rights and funds, and the committee believes need		relating to protection of client rights an any other areas that could include infrir clients' rights.	d funds, and	
V Jagas	Based on observation record review, the far Human Rights Commendations for make suggestions to practices and prograph protection of client mother areas that the	inot met as evidenced by: ons, staff interviews and acility falled to implement mittee (HRC) alled to review, monitor and o the facility about its ams as they relate to lights and funds, and any committee believes that ment of the clients' rights.				
	of a restrictive meas	eview and approved the use				,
	Observation on F	ebruary 26 - 28, 2007,		For WIZE and WIZE Sec response to WIZE.		4/26/20

W1021/041 PRINTED: 03/15/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION ... DENTIFICATION NUMBER: COMPLETED A, BUILDING B. WING 096010 02/28/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE. NE CARECO 01 WASHINGTON, DC 20001 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX FIFER REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG الويون سيد جو ياؤوه الويون الدور والويون الويون DEFICIENCY) ₩ 264 Continued From page 23 W 264 revealed that the facility has door alarms placed on all exits throughout the facility. Further observation revealed that when the door was opened it activated the alarms, which had a double tone ring to alert the direct care staff. Interview with the QMRP revealed the alarms were place on the door due to Client #5's elopement behavior and Client #2 history of elopement behavior. Further interview with the QMRP did not evidence that all the client residing in the facility had been included in the selection of ٠, .. the type of alarm tone and/or participated in exploration of other least restrictive options prior to implementing the door alerts. المعمد المعمد المرابع المرابع Review of the records failed to evidence that all the other client's and/or their representative had been informed of their rights prior to the alarms installation. Further review of the records failed to W 1 provide evidence that the Human Rights Committee had review and discussed the installation of the door alarms, other least restrictive measures and the rights of all the other client living in the facility. W 322 483.460(a)(3) PHYSICIAN SERVICES W 322 The facility will provide preventive and general medical care by complying with DDS policies on providing each client with an accurate regularly The facility must provide or obtain preventive and reviewed, and updated Health Care Management general medical care. Plan. The HCMP is produced by the RN and approved by the PCP. The HCMP contains those medical supports and interventions deemed necessary by the physician for the acquisition and maintenance. This STANDARD is not met as evidenced by: of optimal health for each client served. The RN will Based on observation, interview and record transpose the protocols required in the HCMP to a review, the facility failed to ensure general and 24-hour medical shift log that provides directives to preventive care for three of the five residing in the staff on each support they are to provide, and facility. (Client #1, #3 and #4) $_{I=j,\xi ,}^{(j,l,j)}$

The findings include: 心的心理的。2557(02-88) Previous Versions Obspiete

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vice versa.

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contains areas for nursing to staff communication and

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DEPART	TMENT OF HEALTH	I AND HUMAN SERVICES		•	, , .	D: 03/15/2007 VI APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			1 1	D. 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(XB) CATE	
		090010	B. WING		02/	/28/2007
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS. CITY, STATE, Z	IP CODE	
CAREGO	01		ļ	6417 KANSAS AVE, NE WASHINGTON, DC 20001		
(AS	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCE) TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
322		care staff and record review of	W 32	The RN will confirm the pt day nap for Client #3 and o term "mid-day" to see if tal	btain clarification of t	ihe
	approximately 11:3 was prescribed a "			from the day program meet	s the PCP's intent.	4/26/200
A Comment of the Comm	is usually fired from According to the Q hoome from the da personal hygiene C the bed to rest. Fucare staff revealed tack the nap at the own in his bed to returns from the daclient does not tak to the difficulty of viransported from the			Con recognition WIRO #2		4/26/200
	physicians's order approximately 10: was prescribed a 'adaptive equipmer QMRP revealed the transferred to the collar came with his the QMRP, the clie to provide him necessity of the Phydated 10/13/06 fa	P and record review of the on February 28, 2007 at 15 AM, revealed that Client #1 'Cervical Collar" as a piece of nt. Further interview with the lat when Client #1 was agency two years ago "the im". According to interview with ent is to wear the collar at night ek. sical Therapy assessment ited to reflect the purpose, and length of time for the use		See response to W189 #2.		,,
A SAN AND AND AND AND AND AND AND AND AND A	of the collar, as we for direct care state implementation for Further review fail	and length of time for the use all, did not provide instruction if to ensure appropriate r this prescribed support, ed to revealed that a protocol ed by the nursing staff and that				

	IT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SUP	(X2) MI II 7	TIPLE CONSTRUCTION	FORM APPROV		
	- CONNECTION	IDENTIFICATION NUMBER	A BUILDIN		(X3) DATE	SURVEY LETED	
	·	09G010	B. WING_		111		
NAME OF	PROVIDER OR SUPPLIER		- / -			28/2007	
CARECO	O 01		6	REET ADDRESS, CITY, STATE, ZIP COD 1417 KANSAS AVE, NE	E		
*(*4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES		WASHINGTON, DC 20001			
AG	REGULATORY OR I	Y MOST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)		COMPLETI DATE	
₩ 322	Continued From pa	age 25	W 322		-{-}		
,	no documentation of nursing staff monitor this neck support for	was availble to support the pring of the implemtation of pr Client #1.	VV 322				
	direct care stall had	nual failed to evidence that d been in-serviced on the maintenance of this soft cribed for Client #1.		·			
GAL A FRE TA	11:30 AM, revealed consult on 6/1/06, indicated a "Left bre evaluation-Lt breast records revealed the completed 8 months the medical record cresults of the mamm	mass". Further review of the at a mammogram was alate on 1/10/07, however, did not evidence a copy of the nogram.		The Facility Director will obtain the mammogram. Grand Rounds in the seled by the Registered Nurse, who wi medical reports are received as soon completed and are filed in each client	facility will be	4/26/20	
A SHIRE PAU	nave mailed the test interview with the numer a follow-up apposingical consult "son need the mammogra of the mammogra of the with the 2007 at approximate for a tap approved the us rocedure for Client according to the minuse of sedation for the	paseline Colonoscopy. The see of sedation for this #4 at that same meeting, utes Client #4 requested the e procedure, the QMRP revealed that the		See response to W125 #2s 1 and 3.		4/26/200	

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES	-		ļF		03/15/2007
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		<u> </u>	lo		APPROVED 0938-0391
	of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIPLE CONSTRUCTION		COMPLE	JRVEY
	·	09G 010	B. WII	NG		02/2	8/2007
MAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	1 02121	5/2007
स इ. ४८७२ REGO	01			6417 KANSAS AVE, NE			1
¥	-			WASHINGTON, DC 20001			
PRIFIX AG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION	LSHONI	nia⊨	(X5) COMPLETION DATE
W 322	Continued From pa	ge 26	W.	322	-	 	
e H	_	cedure had not been obtained.	,	322	1	Ì	!
. W 331	483.460(c) NURSIN	IG SERVICES	W:	331 The Director of Nursing will ensu	ure Gran	d Rounds	.
	The facility must pro-	ovide clients with nursing nce with their needs.		are held at least monthly and are the Designated LPN, and the QM issues and required follow up will	attended IRP. All	l by an RN health	
	TOTAL PROPERTY OF THE PROPERTY	mar man anda mooda.		accordance with physician's order			4/26/2007
	TIL OTANOAGO				Ì		7/20/200
A ST	This STANDARD I	s not met as evidenced by: and record review, the facility			}		
4 .	failed to provide ea	ch client with nursing services			į		į
	in accordance with	their needs.					}
HIST.	The findings include	e :					
1.2	1. Interview and re	cord review revealed that		The BOXT Was all a state	0)		,
124) 145	Client #1 had a den	matology appointment on		The DON will coordinate with the that the client returns for the folk			
The state of the s		cheduled to return 1 month appointment. At the time of			•		//0-/22-
signatura.	the survey, the nur	sing staff failed to provide		·	İ		
₩ W		t#1 return in November as					}
	recommended.	·					
	2. Interview and re	cord review revealed that					
	Client #1 had a Uro	logy appointment on 5/12/05	1			!	4/26/2007
1;		to return 1 year later for a ent. At the time of the survey,		See response above.	ļ		71007001
3	19 months later, th	ere was no evidence that the			1		
¥.	nursing staff ensure	timely follow-up as			Ī		
	recommended.					!	
lo id	3. Interview with th	e nurse and review of the		The DON reviews medication re-		ekly, and	4/20lant
ę. 1,1		tration Records on February		will provide training and follow to medication and/or documentation		ses on	الصاور
10 mm	zo, 2007, revealed be applied three times.	an order for Minerin Cream to les a day to the buttocks and		in the state of th	. 00.5.]	
	inner right thigh in t	he diaper area of Client #3.		The DON will coordinate with th	a Dime	or of	, ,
Secure as any dis-	Further review of th	e MAR revealed that the MAR		Disability Services to establish a		or or	4/26/2007 4/26/2007
(8.4) P105	had not been signe	σ.		documenting topicals and rinses.			į ,
The state of the s	Interview with the D	ON indicated that the staff				i İ	
Commence							<u></u>

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES		r	PRINT	च्छाएउ⊥७७४ ≣D: 03/15/2007
	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION	OMB N	RM APPROVED 10. 0938-0391 SURVEY PLETED
		09G010	E. WING			14143
11.1	PROVIDER OR SUPPLIER		· 6	TREET ADDRESS, CITY, STATE, ZIP CODE	02	/28/2007
FARECO				6417 KANSAS AVE, NE WASHINGTON, DC 20001		
WI OXA) ID FIREFIX VAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR		(X5) COMPLETION DATE
A Parks,	direct care staff have them to document a topical treatment. The system had been es implemented to ensufficient to pical treatment as implemented to ensufficient to ensuffici	s cream during diaper terview revealed that the e no access to a MAR for dministration of Client #3's lere was no evidence of a tablished and was being lire implementation of Client al treatment. nurse and review of the ration Records on February n order for Chlorhexidine	W 33	DEFICIENCY)		4/26/2007
t s	Further review of the had not been signed. Interview with the DC care staff give this ringular review revestaff have no access document administratives.	MAR revealed that the MAR for administration. ON indicated that the direct se during toothbrushing, ealed that the direct care to a MAR for them to lion of Client #5's mouth no evidence of a effective tablished and implement				
ne ne ne ne ne ne ne ne ne ne ne ne ne n	evealed that Client #3 Nedication in the PM: 5 ml, Simethicone 40 00 mg, Dilantin 50 mg Il as described below) During the administ t the nurse hand	iration of Diocto, the Client		See response above. The DON will pro additional training to medication nurses facility policy and procedure for docum amounts of medication not administered of medication not administered.	on the enting and dispo	sal 4/26/2007
© # CMS-2587(0	02-99) Previous Versions Obs	plete Event ID: 970J11		ity ID: D9GD10	!	1

TATEMEN	F OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION .		MB NO	M APPROVE D. 0938-039 SURVEY
-,	1 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	PENTITICATION NUMBER:	A. BUILD	ING	- `	COMP	LETED
		09G010	B. WING	 '	H	02/	/28/2007
ARECO	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COD 6417 KANSAS AVE, NE WASHINGTON, DC 20001	≣	021	28/2007
(X4) ID FREFIX (TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	LIGHT.	> >=	COMPLETI
№ 331	Continued From pa	ge 28	W 33		+		
	Zypreza (crushed a Approximately 20%	istration of the Dilantinand nd placed in aplesauce) of the mixture remained in carded in the kitchen				1	
Ga Bo	client refuse their m medication are not a on the MAR and in a percentage amount administered. Addit administered is to b system and docume documented with th	urse revealed that when a sedication and portion of the administered, a note is placed the nursing notes detailing the of the medication not iconally, any medication not e flushed down the sewage ented. The records are to be e date and time the troyed and signed by the					
 W.1	and the nursing note documentation for t medication not adm	ation administration records es failed to evidence any ne percentage amount of inistered and that the nestroyed as required by and procedures.					
1	physicians's order or approximately 10:15 was prescribed a "C adaptive equipment. QMRP revealed that transferred to the ag collar came with him	and record review of the in February 28, 2007 at AM, revealed that Client #1 ervical Collar" as a piece of Further interview with the when Client #1 was ency two years ago "the ". According ti interview with the is to wear the collar at night		See response to W189 #2.			4/26/26
	Review of the media written protocol for t	l record failed to evidence a he direct care staff					

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Mar 29 07 01:51a Home Office

	•	I AND HUMAN SERVICES & MEDICAID SERVICES		,	٠,	i	FORM A	03/15/2007 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		LE CONSTRUCTION		3) DATE SU COMPLET	
		09GD10	B, WIN	G			02/28	/2007
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	1	,	
CARECO	01				(7 KANSAS AVE, NE ASHINGTON, DC 20001			
(X4) ID FREFIX TAG	(ÉACH DÉFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	JULI	βBĖ	(X5) COMPLETION DATE
₩ 331	Continued From pa	ge 29	W 3	31		Ţ.	<u></u>	
ga DW sk	implemtation of Clie prescribed by the p review failed to evice	ent #1's Cervical Collar rimary care physician. Further dence that the nursing staff ect care on the proper use and						
W 362	483.460()(1) DRU	S REGIMEN REVIEW	W 3		The QMRP and the DON will ensure reviews occur on a quarterly schedule		pharmacy	4/26/2007
		nput from the interdisciplinary. he drug regimen of each client						
April 1	Based on staff inter facility failed to ensi medication regime:	is not met as evidenced by: rview and record review, the ure that each client's n was reviewed by the ly, for three of the three clients ant #1, #2 and #3)						,
W:	The findings includ	e:						
	records revealed the pharmacological reduced in According to the number occurred in Juliane of survey, the facility to review the	nurse and review of the medical hat Client #1, #2 and #3's last eview occurred on 10/30/06. Jurse, the next review was to anuary, 2007. Although, at the pharmacist arrived at the emedications regimen of each ad not occurred timely as gulations.						
~-W 365	and #3 are prescrit manage each their behaviors.	further noted that Client #1, #2 bed psychotropic medication to clients's identified maladaptive G REGIMEN REVIEW	w s	365	See response to W331.			4/26/2007
H AR		cation administration record						

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must be maintained for each client.

Event ID: 970J11

Facility ID: 09G010

If continuation sheet Page 30 of 37

SALEMEN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CONSTRUCTION			O. 0938 - 0
		DENTIFICATION NUMBER:	A BUILD		(*		SURVEY LETED
	, 	09G010	B. WING)			
AME OF	PROVIDER DA SUPPLIER					02/	28/2007
CARECO	0 01		١	TREET ADDRESS, CITY, STATE, ZIP COD 6417 KANSAS AVE, NE WASHINGTON, DC 20001	E		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF COR			
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	21.752.00		COMPLE DATE
₩ 365	Continued From pag	ge 30	W 36				
enegapin englep 12 englep	, 				[.]		
, ; :	Triis STANDARD s Based on observation	not met as evidenced by: on, interview and record		1			
. je	review the facility fai	led to maintain medication					
	administration recon	(MAR) for one of the two					
. ' . .	client in the sample.	(Clients #1)					
	The finding includes	;					
	1.) During the verific	ation of the medication pass			1		1.11
٠. ا	and textem wiedication	On Administration Record 1.		See response to W331 #3.			14/26/2
	MAR after administra	n nurse falled to sign in the stion of the following clients				•	
	medications:	and rollowing clicits					
	Interview with the nu	So and rovious of the		•			
. 1	Medication Administr	ation Records on February			1 1		
	40, 4007, revealed a:	order for Minerio Costo to 1		·			į.
VV	inner right thigh in the	s a day to the buttocks and diaper area of Client #3.		·			
	united testion of the	MAR revesied that the Mart					1
	had not been signed.						
. 1	Interview with the DO	N indicated that the staff					
	may may applied this	Cream during diagon (1
· (Changes. Further into	Prview revealed that the			1	,	
\ \t	hem to document an	no access to a MAR for ministration of Client #3's					
1 4	opical treatment, The	Te was no evidence of a					
. §	iystem nad been esta	iblished and was being] [į	<u>:</u>
, #	mplemented to ensur 63's prescribed topics	e implementation of Client I treatment.	,				
· ₂) Interview with the	nurse and review of the					
(1	nedication Administra	tion Records on February		G., ,		j	4/26/20
. 14	o، 400/, revealed an	Order for Chlorhevidina	İ	See response above.			7/26/20
N	vith 15 cc twice daily	ng to the order this rinse after brushing for Client #5.					
7.5		The second of the second secon		•	-1		

								同 0 9 9 7 0 4 7
DEPA _ CENT	ARTMENT OF HEALTH	HAND HUMAN SERVICES & MEDICAID SERVICES					PRINTE	ED: 03/15/2007
		(X1) PROVIDER/SUPPLIER/CLIA	_,			<u>. </u>	OMB N	RM APPROVED 10. 0938-0391
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M A. BUI	ULTIPLE CONST	RUCTION		TAC (EX)	SURVEY PLETED
į		B05044	B. WIN			<u>-</u> j	1	
NAME O	F PROVIDER OR SUPPLIER	09G010	B. VVII			-	02	2/28/2007
CARE				STREET ADDRE	SS. CITY, STATE	ZIP CODE		
CARE		•	· 1	5417 KANSA	S AVE, NE		1	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		ON, DC 2000	1	<u> </u>	
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI; TAG	^ (EAL	ROVIDER'S PLAN CH CORRECTIVE , S-REFERENCED T DEFICIE	ACTION SHO O THE APPR	cuio ee	(XE) COMPLETION DATE
W 36	1 m. Laud 1 10111 PQ	ge 31	VA/ -2	GE .			<u> </u>	
i Linguis MiOma	Further review of the	e MAR revealed that the MAR If for administration.	E W	0 3)	-	ļ		
" !"	1				•			
	Further interview rev	OON indicated that the direct inse during toothbrushing vealed that the direct care			•			
EV.	document administr	s to a MAR for them to						
	i system nag been es	is no evidence of a effective tablished and implemented to		The DON v	will coordinate w	ith the Phan	macist to	
	treatment.	ion of Client #3's gum		ensure prop	er labeling of m	edications.		4/26/2007
; W 389	483.460(m)(1)(il) DR	RUG LABELING	8E W	39				
	コーいじ せいいけいけいおだら さんぐら	nd biologicals must include ssory and cautionary						
	instructions, as well applicable.	as the expiration date, if						
and the same of	I based on observation	not met as evidenced by:						
la siky	medications were lab information for one or	cility failed to ensure that eled with the appropriate f the three client's in the				İ		
	sample. (Client#1)	, and distribute						
	The finding includes:							
:	a manager triedication	nsure that Client #3's topical was properly labeled as						
	CANDELICE DEIOM.							
	Interview with the nurs Medication Administra	ation Records on Eshause.						-
, }	order for Minerin Crea	In to be applied three times						
	a day to the buttocks a dlaper area of Client #	and inder right thich is the		-				
- 4	7(02-99) Previous Versions Ob		E.	Elly (D) OBG010				
1 m 2 c t 1 m 2 c t			1.5			lf continua	tion sheet l	Page 32 of 37
) - 1) - 1								•
2								
13.5					·			

•	•	1			ì	1 4	4 V V V V V I
CENTE	RS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES		·		FORM): 03/15/200 APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		OMB NO X3) DATE S COMPL). 0938-039° BURVEY ETED
	•	09G010	B. WING			1	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	REET ADDRESS, CITY, STATE, ZIP COI	<u> </u>	<u>i 02/2</u>	8/2007
CAREC	· · · · · · · · · · · · · · · · · · ·		1	6417 KANSAS AVE, NE WASHINGTON, DC 20001	3E		
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOİLL	n'a care	(X5) COMPLETION DATE
[†] W 389	Continued From pa	ge 32	W 389			/	
W 436	bedside table in Clichave a label with Clichave a label with Clichave and administration 483.470(g)(2) SPACThe facility must fur and teach clients to choices about the unhearing and other pand other devices in	DE AND EQUIPMENT nish, maintain in good repair, use and to make informed se of dentures, eyeglasses, pommunications aids, braces	W 436	The QMRP will follow up with the notes reflect purchase requests for equipment. The QMRP and PT will the adaptive equipment vendor to equipment is delivered timely.	adaptir l follo	c wunwith	
(9):	review, the facility fa	s:					
2.17.	approximately 6:00 to Client #3 having divined wheelchair. Interview with the Qrecords revealed a remade for the purchasion 2/21/05 for the clithe QMRP revealed ordered and that the the purchase order at the QMRP the 719A forwarded to the app	MRP and the review of ecommendation had been se of an adaptive wheelchair ent. Further interview with that the wheelchair had been pT needed to follow-up on and the 719A. According to had been approved and roprlate parties for approval vendor several months ago.					
RM CMS-256	7(02-99) Previous Versions D	bsolets Event ID: 970J11	— Fac	ility ID: 09G010 f cor	Mouat	i	

. •		•			B		10015041-
DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			,	i PRINTET): 03/15/2 007
CENT	<u>ERS FOR MEDICARE</u>	& MEDICAID SERVICES				FORM	(APPROVED
ISTATEME	INT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIED/OUA	(X2) MU	LTIPLE CONSTRUCTION		<u>OMB NC</u>	<u>), 0938-</u> 0391
AND FLAG	A OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	·	-11°	COMPL	URVEY
	•		i	_ 			ETED
		09G010	B. WING		-11	0.00	n 100 4 W
NAME DE	PROVIDER OR SUPPLIER		s	TREET ADDRESS. CITY, STATE, ZIP CODE	+	1 02/2	28/2007
CAREC	CO 01			6417 KANSAS AVE, NE	٠		
7544 In				WASHINGTON, DC 20001	;		
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	-	in er⊢	(XS) COMPLETION DATE
W 436	Continued From page	ge 33	W 43	6	+	<u> </u>	
	D		•••] . E	
	Review of the PT no	otes indicated that his last			:		
٠.	the purchase of Clie	8/30/06 made no mention of ent#3's new wheelchair.	,				1
	I Keylew of the HRC	Minutes dated 10/26/06	•				!
•	Indicated that Client	#3's new wheelchair was			1	ľ	
W 454	ordered.	TION CONTRACT		1			
	483.470(I)(1) INFEC	TION CONTROL	W 454		ļ		
1	The facility must pro	vide a sanitary environment		See response to W249. The QMRP w staff to complete additional refresher	ill sc	hedule ali	11 / _
4	to avoid sources and	transmission of infections.		infection control procedures.	1 1	mg m	4/26/2007
1000			•	· ·			
52	This STANDARD is	not met as evidenced by:					
i Mariana annotata	l dased on observatio	In and staff interview the					
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	! Tacility failed to main	tain a sanitary environment to ansmission of infection,					,
	The finding include:						
,	During observation of	of the medication		1			. }
	administration on Fe.	bruary 26, 2007 at			11		
	approximately 5:47 F	M. Client #1 while in the				.	
	He repeatedly spit in	hibited a spitting behavior.			11]	
1	assigned to the client	t repeatedly days him a dou			$\mid \cdot \mid$		1
	habet towel to wide H	us hand and encouraged the			11	·	
	nurse to speed up the process.	e medication administration			 -		
	p. 00633,				ļ.		
λ /	The medication nurse	e administered the client			$\ \cdot \ $.
e 1	medication and the 1:	:1 Staff proceeded to take					
, ,	At no time was staff of	g room table for his dinner. Observed to take the client				1	1
7 (1)	into the bathroom to v	wash his hand.		· ·			1
" to de recons						ļ	
	Interview with the QM revealed that one of C	IRP on the same day, Client #1's target behaviors			11	İ	
: - I	was to decrease spitti	ing and the behavior support				1	
	7(02-99) Previous Versiona Ob						
230	Marae) Lievions Aetelona Op	esglete Event ID: 970J11	Fec	ality ID: 09G010 If contin	ustic	on sheet D	age 34 of 37

DEP	ARTMENT OF HEALT	H AND HUMAN SERVICES	r		BRINE	#₩ n 2 a > û 4 \
	TENS FOR MEDICAR	E & MEDICAID SERVICES		•	, LKINI	ED: 03/15/200 RM APPROVE
	HENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION	(X3) DAT	NO. 0938-039 E SURVEY PLETED
}	·		!			reeigp .
NAME C	OF PROVIDER OR SUPPLIER	09G010	B, WING		11 0	2/20/504-
CARE			j	TREET ADDRESS, CITY, STATE. ZIP CODE 6417 KANSAS AVE, NE	02	2/28/2007
(X4) E PREFI	SUMMARY STA	TEMENT OF DEFICIENCIES	1 —	WASHINGTON, DC 20001		
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
W 45	I TOTTI BE	ge 34	142.45		<u> : </u>	
 	plan outlined proces	dure to wash his hand on each e spits in his hands.	W 45∠	1		
. W 458	Review of the medic orders revealed that carrier. 483.470(I)(1) INFEC	cal records and physician's Client #1 is a Hepatitis B	W 455	The QMRP will ensure that all staff re	solve refre	•
	and communicable			training on infection control procedure where necessary, habilitation program appropriate infection control protocols to W454.	s, and that	}
(X)	that procedures for p disease were implem in the sample. (Clien	not met as evidenced by: n, the facility failed to ensure revention of communicable lented for two of three clients t #1)				
154	The finding includes:					
W 474	The facility failed 1:1 failed to ensure infecting implemented. [See V 483.480(b)(2)(iii) ME/	staff assigned to Client #1 tion control practices were V454] AL SERVICES	W 474			
	Food must be served developmental level of	in a form consistent with the f the client.		See response to W189 #1.	ŀ	4/26/2007
	review, the facility faile	ot met as evidenced by: staff interviews and record to serve foods in a form orders for two of the three . (Clients #1 and #2)				
1	The finding includes:	·				
	The findings include;				j	
V CMS-256.	7(02-69) Previous Versions Obs	olete Event ID: 970J11				
		באפונו וה: אנחזון	Facilit	y ID: 09G010 If continuat	on sheet P	age 35 of 37
				·		•
						•
		•				

DEPART	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			[:	FOR	D: 03/15/2007 MAPPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		MB NO	0,0938-0391 SURVEY
		09G010	B. WING			İ	
CARECO	ROVIDER OR SUPPLIER		s	TREET ADDRESS. CITY, STATE, ZIP CO. 6417 KANSAS AVE, NE WASHINGTON, DC 20001	DE .	02/	28/2007
(X4) ID PREFIX TAG	(Each Deficiency	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	マンハヴェロ	5 e=	(XS) COMPLETION DATE
	2007 at approximate large chucks of bee! The direct care was	ne dinner on February 27, sly 6:13 PM, revealed very I stew on Client #1's plate. observed to repeatedly look	W 47	See response above.			4/26/200
	size of the beef chuch large." Interview with the Qinterview with the Qinterview to chopping it as presonable she never wen size of the beef chuch staff provided the co		٠.				
VV is	prescribed a 1800 can Cholesterol chopped 2. Observation of the 2007 at approximate large chucks of beef The direct care was however, did not conclucks on the plate.	der revealed that Client 1 is alorie Low Fat/Low I texture diet. e dinner on February 27, sly 5:13 PM, revealed very stew on Client #2's plate. look at the meat on the plate, nment on the size of the beef. The direct care staff picked and began to cut the chuck		See response above.			4/26/2007
5	The staff the okay to so the staff the okay to so the never went size of the beef chuck staff provided the contact of the cont	Ţ.					
r	rescribed a Regula	der revealed that Client 1 is r, Chopped meat, No /No Caffeine - No Grapefruit.					

STATEMENT ND PLAN O	RS FOR MEDICAR OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S	HÉBRIED/CLIA	(X2) MU A. BUILI	ILTIPLE CON	STRUCTION	1			OMB N (X3) DATE	M APPROV O. 0938-0 SURVEY LETED
MARIN OF T	<u> </u>	09	G010	B. WING	·					! 	
	ROVIDER OR SUPPLIER	· · · · · ·			TREET ADD	BEGS CITY		-	41	02	/28/2007
CARECO (X4) ID	<u> </u>	-			9417 KAN	SAS AVE, N GTON, DC	1E				
PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	ATEMENT OF DEFICE Y MUST BE PRECED SC IDENTIFYING IN	ENCIES ED BY FULL FORMATION)	ID PREFIX TAG	. ()=	PROVIDER ACH CORRE	SPLAN	OF CORRE			(X9) COMPLETI DATE
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	•							-		•	

	Regulation Administra	ation				FORM	APPROVE
STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER;	(X2) MUL A, BUILD!	TIPLE CONSTRUCTION NG	(X3) DATE	SURVEY LETED
		09G010		B. WING		no.	28/2007
VAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE	11 421.	2012001
CAREC	· · · · · · · · · · · · · · · · · · ·		WASHING	ISAS AVE, ITON, DC	NE 20001		
PREFIX	(SACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	⊈ina I	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE J DEFICIENCY)	รษณ์เมโกคะ	(¥5) COMPLETE DATE
000	INITIAL COMMENT	rs		1 000			
٦	sample of three clie	was conducted from lebruary 28, 2007. A solution in the conducted from ales with varying deg	random n a client				
ا د ا	observations at the program, interview was management, and a	urvey were based on group home and thre with direct care staff a review of the habilite ds to include the unu ile.	e day				
.1 040		ICE / DINING AREA provide each residen inced diet.	i	l 040	The QMRP will ensure that the Reg provides a refresher training on clic facility staff.	ristered Dietician nt diets for all	4/26/20
<u>.</u>	This Statute is not n Based on observation review the GHMRP to with a nourishing, we	net as evidenced by: on, interview, and reco failed to serve each r ell-balanced diet.	ard !				
	The finding includes:				,		
	See Federal Deficier and W474	ncy Report Citation \	1450 erra	•	· ·		
1 082	3503.10 BEDROOM:	S AND BATHROOM	s	1082	SIG	_ \$P [
17. 17.	Each bathroom that i equipped with tollet to dispenser, soap for hadequate lighting.	issue, a paner lowel :	and cun	. }	The QMRP will ensure that all bath properly equipped with cups, toilet paper towels, and that light bulbs are	paper, soap and	4/26/20
10 July 1	This Statute is not m Based on observation	et as evidenced by: ns observation and in	nterview			· ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	
RATORY	L. St. Sturings. DIRECTOR'S OR PROVIDE	ME Divector	of Disa	Waility	Services TITLE	3/27/	(X6) DATE
E FORM		· · · · · · · · · · · · · · · · · · ·	400		70J11	II If continue	Jon sheet 1 of 7

Mar	29 07 01:56	a · Home Of	fice		301-441-1329		***	p. 7	
/// /// Widestin (Regulation Administr					Ħ٢	FORM	: 03/15/2007 APPROVED	,)
	NT OF DEFICIENCIES					<u> </u> 			7
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		4	IPLE CONSTRUCTION	κ	B) DATE SI COMPLE		
				A. BUILDIN B. WING					
NAME OF	PROVIDER OR SUPPLIER	09G010	OTBEETAD	L		Щ	02/2	8/2007	
	· .			NSAS AVE, I	STATE, ZIP CODE				
CAREC			WASHING	STON, DC 2	0001				
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY	S	ID	PROVIDER'S PLAN OF CORRECT	Ϋ́O	N	(X5)	+
, TAG	REGULATORY OR L	SC IDENTIFYING INFORMA	ATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	냶	rate Riate	COMPLETS DATE	1
				<u> </u>	DEFICIENCY				
1082	, , , , , , , , , , , , , , , , , , ,			1082	·				ì
	at the GHMRP fail	ed properly equip eac appropriate items to r	ch	<u> </u>					
· , · . (*)	residents need.	appropriate items to t	neer each						1
Maria (l
	The findings include	e:		·					1
r Paris.	During the environr	mental walk-through	on					, .	
	February 28, 2007 revealed the follow	at approximately 11:	15 AM	}					
				i					
	1. The bathroom or	n the basement level enser and no paper t	had no		-			İ	
7. 1	the residents use.	meer and No paper t	Owers 101						
12.1	2. The main layed h	athroom adjacent to	0!-						
	#3's bedroom had r	no paper towels, cup	resident s and	,					
	cup dispenser.	. ,							
	.3. The second leve	el bathroom #3 and #	f4 had no						
. [1	cups and cup dispe	nsers.			· .				
<i>į</i> .*	4. Bathroom #2 and	d #3 had bulbs which	were not					1	
``	working,		. 110/01/10	1			•		-
i nan	2504 1 1101165755	TRINIO							
	3504.1 HOUSEKEE	EPING		1 0 8 C	The CMTP will ensure that II			,	1
The A	The interior and ext	erior of each GHMRI	shall be		The QMRP will ensure that all unused are properly and safely stored, and the	TUI a	nishings working	4/26/200	Į,
,	and sanitary manne	e, clean, orderly, attra er and be free of			thermometer is in the freezer.		- ,	1700	1
	accumulations of di	rt, rubbish, and objec	tionable	1					ł
	odors.				.		i		ì
	-		.						
	This Statute is not in Based on observation	met as evidenced by on during the environ	: Promtál			$\ \ $			
	walk-through the Gi	HMRP failed to maint	tain the		ı		İ		1
,	facility in a safe, clear manner as evidence	an,orderly and sanita	ry (
		•							
A Man	The findings include	ž.			<u> </u>	Ш	•	1	
: no regui 147€ ≅ORI	ation Administration V			1699 (770J11	ĦΤ			1
			•	ž.	71.041.]		If continual	lion sheet Z of 7	,
n harring Miller gra									
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!!ealth (Regulation Administra	ation					PRINTE FORI	D: 03/15/2 M APPRO
-SWATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA MBER:	A. BUILD			Ka) DATE	SURVEY LETED
		09G010		B. WING				
	PROVIDER OR SUPPLIER				, STATE, ZIP CODE	M(!) M: T	02/	/28/2007
CARECO			WASHING	NSAS AVE, GTON, DC	NE 20001			
(X4) ID PREFIX TAG	(CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SCHOENTIFYING INFORMA	E1 11 4	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	are illui le	3 55	(X5) COMPLE DATE
1 090	Continued From pag	je 2		1 090			~-	
	INTERIOR						,	
	 A mattress and b next to the furnace. 	ox spring was being	stored					
	A broken head be hangers were being bathroom.	pard and a pile of coa stored across from t	at he					
rigis.	3. No thermometer w refrigerator freezer.	as being stored in th	ie					
<u>4</u> 7.			-				,	
		•		1				
	EXTERIOR				•			
1	3504.6 HOUSEKEEP			1095	The QMRP will ensure that poisons a agents are properly stored and locked	nd da	ustic	4/36/20
, ,	Each poison and caus a locked cabinet and of each resident.	stic agent shall be st shall be out of direct	ored in reach		. , , , , , , , , , , , , , , , , , , ,			7724782
f.	This Statute is not me Based on observation ailed to lock caustic a	and interview the C	HMRP					
}	he findings include:							
"	During the environmer ebruary 28, 2007 at a evealed the following:	inntaximataly 11 on	РМ		<u>:</u>			
,	Caustic agents wer te basement bathroom on Administration	e being stored under n sink unlocked.	rneath					-
E FORM			6490	97	OJ11	IF.	continuati	on «հթ≘t 3 o
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of the second					'			
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STATEME PLAN	ENT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIE (DENTIFICATION NU 09G010	RVCLIA MBER:	(X2) MUL A. BUILD B. WING		CC	ATE SURVEY DMPLETED
NAME OF	PROVIDER OR SUPPLIER		STREET AC	DRESS, CITY	, STATE, ZIP CODE		02/28/2007
CAREC	0 01		6417 KA	NSAS AVE, Ston, DC	NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	मागा	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	dilii b se i	(XS) COMPLETE DATE
1 095	Continued From pa	ge 3		1 095			
1 180 50 A ANG	the main level baths 3508,6 ADMINISTR Documentation that as required by each Habilitation Plan Inc.	services have been resident's Individual luding contracts, ver ts, and paid bills sha	provided al idor Il be	1188	The Director of Operations will ensu contracts with day programs are on f facility.		
JAANT .	available for review personnel. This Statute is not represent the Based on interview and GHMRP failed to en	by authorized regula met as evidenced by and record review th sure that contract fo for the regulatory ago	ttory : e r outside				
	The finding includes Interview with the Quavailable outside concontractual agreeme which the resident's	MRP and a review or otract failed to show ant for the day progra	evidence				
1189	Each GHMRP shall if funds received and This Statute is not in Based on interview a	maintain records of a disbursed. net as evidenced by: and record review the	_	l 189	The QMRP will ensure that updated, descriptions are on file for each staff annual reviews of the job description with each employee.	person a	nd that
# #	GHMRP falled to ma funds received and o	lintained each residentishursed.	ents				
· '	The finding includes:						
	See Federal Deficier	icy Report Citation V	V140				
ealth Regul	ation Administration M		غا		970J11		allnuation sheet 4 of 7
14. T				. 0	3/15/2007 THU 16:09 [TX/R	X NO 5	270]

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	/CLIA BER:	A, BUILDI		įX3) DATE SU COMPLE	
		09G010		B. WING		` .	02/28	3/2007
MAME OF P	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE	- 		3/2007
CARECO	01		6417 KAN WASHING	ISAS AVE, ITON, DG 2	NE 10001			
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1 203	3509.3 PERSONN	EL POLÍCIES		1 203				
.":	descriptions with ea	all discuss the content ach employee at the b t least annually thereat	eginning					
- Mil.	Based on record re	met as evidenced by: eview, the GHMRP fail iew current job descrip ally.	ed to					
	The finding include	s:		1		·		
CA	February 28, 2007, to provide evidence	onnel files conducted on revealed that GHMRI of current signed job ee (3) direct care staff	P failed					
1 206	3509,6 PERSONNI	EL POLICIES		1 206	·			
	annually thereafter, certification that a h performed and that	ior to employment and shall provide a physic realth inventory has be the employee's heal her to perform the req	ian 's een Ith status		The Director of Disability Serveach employee of the facility has certification.	ices will tr	nsure that t health	4/26/200
		·						
	Based on record re	met as evidenced by: view, the GHMRP fail ew current health cert nnually.		·		****		
	The finding includes						j	l.
	2007, the GHMRP certification for two	onnel files on February failed to provide currer (2) direct care staff	nt health	,		-		
lealth Regul TATE FORI	ation Administration M			1970	970J11		if continual	tion sheet 5 of 7
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STATEMENT	FOF DEFICIENCIES * OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		A BUILDIN		N .		DATE SUI COMPLET	
		096010		a. WING _				02/28	/2007
NAME OF P	ROVIDER OR SUPPLIER		6417 KAN	ress, city, : Sas ave, n Ton, dc 2					
(X4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	(EACH COR	RECTIVE ACTION SI RENCED TO THE AF DEFICIENCY)	IOULD E	9E ∤	(X5) COMPLETE DATE
1.506	Continued From pa	age 5		1 206					
φ.Α'ς.	ÓMRP- ∰ one (DON- and Podi	(1) nurse consultants atrist	[🐴].					ļ	
1 222	3510.3 STAFF TR	AINING		1222					
2. 7 . 0 /		itinuous, ongoing in-s scheduled for all pers			The Director of service training out for all facilit	Disability Services schedule and ensure by staff.	will cra e that it		4/26/200
Tes.	Based on observa- verification, the Gl	t met as evidenced by tions, interview and re HMRP failed to ensure ng in-service training p or all personnel.	ecord	٠.					
	The finding include	es:							
TPRE	See Federal Defic	iency Report Citation	W189						
į 395	3520,2(e) PROFE PROVISIONS	SSION SERVICES: 0	SENERAL	1 395		Disability Services connel have current			4/26/2007
	professional staff of necessary profess accordance with the individual habilitation necessary by the following professional service limited to, those so trained, qualified,	all have available qual to carry out and monitional interventions, in the goals and objective ion plan, as determine interdisciplinary team ces may include, but it ervices provided by in and licensed as requite law in the following as of services:	tor s of every d to be The not be dividuals lred by						
Î CA	(e) Nursing;					•			
	Based on interview GHMRP failed to licenses on file.	it met as evidenced b w and record review, ensure its nurses had	the	i					
TATE FOR	lation Administration			6400	970J11	!		If continue	ation sheet 6 of 7
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STATEMEN	TATEMENT OF DEFICIENCIES ND FLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING				
MAME OF	PROVIDER OR SUPPLIER	09G010	·	B. WING_		<u></u>		02/2	8/2007
	GAREGO 01 6417 K			RESS, CITY, : IAS ÀVE, N ION, DC 2	STATE, ZIP CODE IE 0001			GZIZ	0/2007
(X4) ID PREFIX TAG	I CONCIDENCE	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S	ID PREFIX TAG	PROVID (EACH CO	ER'S PLAN OF CO RECTIVE ACTIO ERENCED TO THI DEFICIENCY)	N SHOUL E APPROI	in ar	(X5) COMPLET DATE
1 395	Continued From page	ge 6		1 396			<u> </u>	 	 -
	The finding includes	3 .					.		
production of the state of the	Review of the perso 2007 revealed that to current license on fil Nurse(RN) employe	ne GHMRP failed to le for one Registerer	have						
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